

March 11, 2019

Tiffany Swygert  
Director, Division of Outpatient Care  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Comprehensive Ambulatory Payment Classification Methodology**

Dear Ms. Swygert,

Thank you for the opportunity to meet with you and your staff on February 12<sup>th</sup> to discuss radiation oncology payment issues. As promised, we are forwarding to the Agency specific recommendations for consideration during the 2020 rule making cycle, related to Hospital Outpatient Prospective Payment System (HOPPS) payments for cervical brachytherapy. Our original recommendations were included in a March 26, 2018 letter to the Agency (enclosed). We have restated our main requests below, maintaining references to the 2018 data for consistency. However, we recognize the Agency has 2019 payment rates/data available.

While we believe that use of the traditional Ambulatory Payment Classification (APC) methodology would address our concerns, we appreciate the Agency's commitment to bundled payments and continued efforts to expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology. If CMS insists on using the C-APC methodology to value radiation oncology services, particularly brachytherapy for the treatment of cervical cancer, we urge the Agency to consider a hybrid approach that would accomplish the following:

- Include CPT Codes 57155, 77470, 77370, 77771 and bundled services (e.g. moderate sedation) in a Cervical brachytherapy C-APC
- Assign cervical brachytherapy to C-APC 5416 Level 6 Gynecologic Procedures
- Allow cervical brachytherapy to be eligible for complexity adjustment
- Report planning and preparation services separately, similar to the SRS policy (e.g. 77290, 77295, 77336, etc.)
- Report EBRT separately
- Continue to report brachytherapy sources separately

Cancer treatment is complex, patients are often treated concurrently with different modalities of radiation therapy, combined with other specialty modalities, and often at different sites of service. The CMS C-APC methodology does not account for this complexity and fails to capture appropriately coded claims, resulting in distorted data leading to inaccurate payment rates that jeopardize access to certain radiation therapy services if continued and expanded. Ultimately, resulting in decreased cancer control rates and survival<sup>1</sup>.

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<sup>1</sup> C.H. Holschneider, D.G. Petereit, C. Chu, et al., Brachytherapy: A critical component of primary radiation therapy for cervical cancer, *Gynecologic Oncology*, <https://doi.org/10.1016/j.ygyno.2018.10>.

CMS' comprehensive APC methodology is a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. CMS makes payment for all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service. Payments for adjunctive services are packaged into the payments for the primary services. This results in a single prospective payment for each of the primary, comprehensive services based on the costs of all reported services at the claim level.

### **Cervical Brachytherapy**

The standard of care for the nonsurgical curative management of cervical cancer includes concurrent chemotherapy with external beam radiation therapy (EBRT) and brachytherapy. Brachytherapy is a surgical procedure to introduce radioactive elements directly into or adjacent to the cancerous tumor. Patients who receive this specific combination of treatment experience high quality outcomes, including longer survival times and lower mortality rates. The effectiveness of this multimodality approach to cervical cancer hinges on evidence that optimal treatment is achieved when all chemotherapy and radiation therapy (both external therapy and brachytherapy) is completed within 56 days or 8 weeks.<sup>2</sup> Exceeding this period results in decreased local tumor control and survival for the patient with each day of delay<sup>3</sup>.

Delivery of brachytherapy for cervical cancer results in control rates as high as 100 percent for stage IB, 96 percent for stage IIB, and 86 percent for stage IIIB patients, yet an analysis of the National Cancer Data Base indicated that of 7,654 patients diagnosed with curative cervical cancer the use of brachytherapy declined from 98 percent to 86 percent between 2004 and 2011. The median survival time was 70.9 months for those treated with brachytherapy compared to 47.1 months for those treated with other modalities.<sup>4</sup>

In the United States, the most commonly used regimens are 45Gy EBRT to the pelvis (possibly with a sidewall boost) with concurrent cisplatin-based chemotherapy and either 5.5 Gy per fraction for five fractions (for patients treated with concurrent chemotherapy who have had either a complete response or have <4 cm of residual disease) or 6 Gy for five fractions (for patients with tumors >4 cm after EBRT).<sup>5</sup>

**In summary, the standard of care for a cervical cancer patient will be external beam radiation therapy/5 brachytherapy insertions/chemotherapy all completed within 56 days of treatment start.**

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<sup>2</sup> Song MD, Suisui, et al. (January 15, 2013) The Effect of Treatment Time in Locally Advanced Cervical Cancer in the Era of Concurrent Chemoradiotherapy. *Cancer*, 325-331.

<sup>3</sup> Petereit MD, Daniel G., et al. (1995) The Adverse Effect of Treatment Prolongation in Cervical Carcinoma. *International Journal of Radiation Oncology Biology Physics*, Volume 32, No. 5, 1995, 1301-1307.

<sup>4</sup> Petereit MD, Daniel G., et al. (March 20, 2015) Brachytherapy: Where Has It Gone? *Journal of Clinical Oncology*, Volume 33, No. 9, 980-983.

<sup>5</sup> National Comprehensive Cancer Network. Cervical Cancer (Version 1.2017). <https://www.tri-kobe.org/nccn/guideline/gynecological/english/cervical.pdf> Accessed March 21, 2018.

Charge Capture

The primary service (J1) in the case of cervical cancer is CPT Code 57155. That service is assigned to APC 5414 with a 2018 payment rate of \$2,272.61.

APC	HCPCS	Group Title	Short Descriptor	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
5414		Level 4 Gynecologic Procedures		J1	28.9004	\$2,272.61	.	\$454.53

All the radiation delivery, planning and preparation are considered adjunctive services and designated with status indicator S. Those charges appear on the same bill as the J1 service (CPT Code 57155).

HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Minimum Cost	Maximum Cost	Median Cost	Geometric Mean Cost
57155	J1	54140	\$2,272.61	1719	1729	\$600.56	\$16,316.39	\$3,079.38	\$3,013.71
77470	S	5623	\$522.28	41039	57294	\$91.53	\$2,116.61	\$443.11	\$442.63
77370	S	5611	\$125.35	26766	34844	\$35.03	\$797.28	\$172.27	\$172.34
77771	S	5624	\$714.06	5687	11435	\$151.64	\$3,074.26	\$715.92	\$730.89

Planning and Preparation codes									
HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Minimum Cost	Maximum Cost	Median Cost	Geometric Mean Cost
77290	S	5612	\$323.07	111404	140318	\$87.82	\$1,851.20	\$392.67	\$393.94
77295	S	5613	\$1,186.60	72804	96841	\$239.99	\$5,269.28	\$1,136.40	\$1,129.38
77336	S	5611	\$125.35	646839	657097	\$30.49	\$584.58	\$135.66	\$132.25

2018 NFRM Final Rule CPT Cost Stats 10.27.17

Packaged Services	
76942	N
77417	N
99151-99157	N

The brachytherapy sources will also appear on the bill. However, sources have a status indicator designation of “U” and are separately reportable/paid.

Brachy Source								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1717	Brachytx, non-str,hdr ir-192		U	2646	3.7462	\$294.59	.	\$58.92

For purposes of this analysis and our recommendations, we are using the CMS 2016 mean data for CPT Code 57155. CPT Code 57155 currently has a status indicator of J1, thus including other services in the mean data. As such, the 2016 mean data for CPT Code 57155, which had a status indicator T at the time, reflects costs associated with just the insertion.

2016 Mean*
\$797.17

\*2016 FR CPT Cost Stats 2015-12-16

As discussed above, the current standard of practice for cervical cancer is five fractions (insertions) of (1) brachytherapy:

HCPCS	SI	Geometric Mean Cost	UoS	
57155	J1	\$797.17	5	\$3,985.85
77470	S	\$442.63	1	\$442.63
77370	S	\$172.34	5	\$861.70
77771	S	\$730.89	5	\$3,654.45
77290	S	\$393.94	5	\$1,969.70
77295	S	\$1,129.38	5	\$5,646.90
77336	S	\$132.25	1	\$132.25

\$16,693.48

and (2) external beam radiation therapy. Again, assuming the hospital is billing monthly, that external beam cost, based on CMS 2018 mean data file, is greater than **\$25,000**. *Note: Assumption that the hospital bills CMS monthly for the cervical cancer treatment, which is standard practice in the field.*

**The 2018 Medicare HOPPS payment for cervical brachytherapy treatment was \$2,272.61:**

- **\$14,420.87 less than average cost** for the brachytherapy portion of the treatment; and
- **\$40,000 less than the average cost** for brachytherapy and external beam radiation therapy (partial treatment).

### Recommendations

We recognize that CMS is committed to the C-APC methodology and support CMS policies that promote efficiency and the provision of high quality care. However, the methodology used to create C-APCs lacks the appropriate charge capture mechanisms; as it is currently applied it grossly undervalues cancer treatments, particularly brachytherapy.

Based on our analysis, we urge CMS to consider allowing brachytherapy to be reported through the traditional APC methodology. However, if CMS insists on the continued use of the C-APC methodology, we recommend that the Agency move brachytherapy for cervical cancer treatment to

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C-APC 5416 Level 6 Gynecologic Procedures. This C-APC is reimbursed at \$6,286.92, which is closer to the actual cost of treatment delivery as noted above. Additionally, we would request that CMS allow the treatment delivery, simulation and physics codes to be separately reportable. This is a similar approach that the Agency has taken with the methodology used for the SRS C-APC in which the planning and preparation codes are separately reportable.

Finally, we ask that CMS recognize the multimodality process involved in the treatment of cervical cancer by allowing separate reporting for the external beam radiation therapy services that occur during a course of care. We believe that these changes will result in more appropriate reimbursement and address concerns regarding access to appropriate care.

We believe these changes to the HOPPS methodology will begin to remedy the egregious underpayment for cervical cancer care. However, similar issues exist for other brachytherapy treatments and we urge the Agency to work with the stakeholders to remedy those payment disparities as well.

Thank you for your consideration of these C-APC recommendations. Should you have any questions on the items addressed in this letter, please contact Anne Hubbard, ASTRO Director of Health Policy, at 703-839-7394 or [anne.hubbard@astro.org](mailto:anne.hubbard@astro.org).

Sincerely,



Laura Thevenot  
Chief Executive Officer

cc:

Carol Blackford  
Edith Hambrick, MD  
Marjorie Baldo